Amendments to the Specification:

Please amend page 9, line 18 as follows:

FIG. 20 is ~~a~~ an explanatory sketch for contact between bone and implant for different implant types.

Please amend the paragraph beginning on page 10, line 30 as follows:

Surfaces 1 and 3 of the side wall preferably are given a micro topography which promotes bone formation and bone compacting in connection with the surface as rapidly as possible. This can be achieved by means of grooves and ridges of optimum size or by means of etching, milling, electrolyses treatment or in another way in order to provide the correct "roughness" for maximum bone binding. The surface can also be treated chemically by entrainment of ~~flour~~ fluorine, calcium ions or in another way in order to further improve the binding to adjacent bone tissue.

Please amend the paragraph beginning on page 11, line 12 as follows:

The intraoral jaw bone ~~crista~~ crest often has a generous width when the bone height is small, which favours tubular implants having a large diameter. Such an implant then can be located so that the side wall thereof buccally (towards the cheek) and lingually (towards the tongue) preferably involve the transient zone between the outer cortical (compact) bone and the intermediate spongy (marrow rich) bone. This zone has plenty of bone forming cells and at the same time allows optimum use of the dense, compact bone, which in studies has been found to promote stability and torsional resistance of the implant due to the fact that this bone has a more or less continuous contact with the implant (Meredith N. 1997).

Please amend the paragraph beginning on page 12, line 7 as follows:

The implant according to the invention can also advantageously be placed directly in a tooth alveolus immediately after tooth extraction or after alveol healing for one or two weeks, which is shown in FIG. 4 where the tubular implant R1 is installed in a

bone ~~crista~~ crest with the alveolus filled with granulation tissue G after a quite recently effected tooth extraction. If the diameter of the implant is adjusted such that the outer diameter thereof is almost as large as or larger than the upper (marginal) diameter of the alveolus the side wall surface of the implant further down (apically) will be surrounded by bone at the inside as well as the outside and eventually will be filled in the lumen thereof by bone ingrowth from the alveolus walls and the alveolus bottom. This is shown in FIG. 5 where the alveolus is completely filled with bone AB as is the entire lumen of the implant including the uppermost portion ÖDB. The implant is provided with a tooth crown TK.

Please amend the paragraph beginning on page 12, line 34 as follows:

Teeth which have several roots such as some forward cheek teeth and the majority of the rear cheek teeth generally have such a bone anatomy that it is particularly ~~favourable~~ favorable to a tubular implant of the type presented herein. In alveoli of teeth having several roots there is namely always in the apical (deepest) portion thereof a central bone portion formed as a ridge or a triangle of the bone located between the tooth roots. If compact implants were to be installed in such an alveolus it should either be necessary to place two implants (two-root teeth) or three implants (three-root teeth) or to place an implant having a very large diameter centrally in the alveolus and it would be necessary to remove the bone ridge or bone triangle by drilling. The tubular implant presented herein can be placed centrally in the alveolus while maintaining said bone ridge. This provides a primary stability, which is unique and moreover the bone ridge can relatively immediately deliver new bone cells and thus new bone for filling of the lumen of the implant. FIG. 6 discloses an alveolus after extraction of a two-root tooth in bone ~~crista~~ crest where the implant R1 according to the invention has been installed. According to FIG. 7 the alveolus and the total lumen of the implant are filled with bone, AB and ÖDB.

Please amend the paragraph beginning on page 14, line 33 as follows:

FIG. 16 to ~~19 disclose~~ 18 discloses a special technique for insertion of the implant according to the invention in the bone of the upper jaw below the jaw cavity and the integration into this jaw bone. The soft tissue which covers the jaw bone (B) has been punched away so that the bone where the implant is to be located (the implant seat) has been uncovered (FIG. 16). In the illustrated example the bone has a relatively smooth surface perpendicularly to the direction for inserting the implant but is not thicker than about 3 mm. After the centre of the implant seat has been marked by means of a small round drill the groove Sp into which the implant is to be screwed is drilled by means of a trephine drill to the desired depth. By means of a lifter having ears the mucous membrane of the jaw cavity is lifted, FIG. 17, and then the trephine groove can be made deeper, so that a tubular implant with a thread height of 6 mm, FIG. 18, can be screwed in to the intended position by means of an implant carrier/tightener which has an inner hex which matches the outer hex surfaces 6 of the tower. The implant is installed with a torsional force, which usually amounts to 30 to 40 Ncm. If the implant is not self-tapping a screw tap is needed which either can be double, i.e. can cut in both the outer and the inner wall of the trephine groove, or can cut only in the outer wall. According to illustration by means of arrows in FIG. 18 bone will grow into the base portion of the implant as well as the tower thereof. FIG. 19 and 20a, b, c shows prior art, while Fig. 20d, e discloses the situation after some months when bone tissue fills the total implant over the original bone level of the implant seat.

Please insert the Abstract page attached into the application as the last page thereof.